U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 22 May 2007

In the Matter of

C.F.[1]
Claimant

Case No. 2003-BLA-00256

v.

U.S. STEEL MINING COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-In-Interest

Andrew Delph, Esq.
Norton, VA
For the Claimant

Howard Salisbury, Esq.
Charleston, WV
For the Employer

Before: JEFFREY TURECK
Administrative Law Judge

DECISION AND ORDER ON MODIFICATION DENYING BENEFITS[2]

This case arises from C.F.'s ("claimant") second attempt to modify the denial of his duplicate claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901 *et seq*. ("Act") and implementing regulations at Title 20, Parts 718 and 725 of the Code of Federal Regulations.[3]

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[1] Effective August 1, 2006, the Department of Labor instituted a policy that decisions and orders in cases under the Black Lung Benefits Act which will be available on this Office's website shall not contain the claimant's name. Instead, the claimant's initials will be used.

[2] Citations to the record of this proceeding are abbreviated as follows: CX – Claimant's Exhibit; EX – Employer's Exhibit; DX – Director's Exhibit; TR – Hearing Transcript. Exhibits within Director's Exhibit 22 are abbreviated as "Ex."

[3] All of the regulations cited in this decision are contained at Title 20 of the Code of Federal Regulations.

Judge Cox denied claimant's initial claim on August 18, 1988 because claimant failed to establish pneumoconiosis (DX 22, Ex. 33). Claimant did not appeal Judge Cox's decision. Claimant then filed a duplicate claim on November 3, 1995 (DX 1). On March 1, 1999, Judge Levin denied the claim because claimant had failed to establish a change in conditions by proving that he had pneumoconiosis (DX 37). Judge Levin also found that claimant was not totally disabled (*id.*). Claimant then requested modification of Judge Levin's decision (DX 38). On April 10, 2001, Judge Holmes denied the request because claimant had not established pneumoconiosis (DX 58). The Benefits Review Board ("BRB") affirmed Judge Holmes in an unpublished decision dated February 13, 2002 (DX 64). Claimant filed the instant claim for modification on January 20, 2003 (DX 65). The case was referred to this Office for hearing on June 2, 2003 (DX 68).

A brief formal hearing was held on August 15, 2006 in Pipestem, West Virginia. Claimant did not appear at the hearing, and no witnesses testified. Claimant's Exhibits 1-5,[4] Employer's Exhibits 1-5, and Director's Exhibits 1-71 were admitted into evidence. The employer contested pneumoconiosis, causal relationship, total disability, causation, subsequent claim, and modification. The record closed at the hearing, and only the employer submitted a post-hearing brief.

Based on the evidence contained in the record of this proceeding, I find that the claimant is still not entitled to benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Claimant is 80 years old, married, and his wife is his only dependent under the Act (DX 1, 5, 37 at 1). The parties stipulated that claimant had 29 years of coal mine employment, all of which was underground (TR at 6; DX 36 at 11, 37 at 1). Claimant worked for U.S. Steel Mining Company ("employer") for 15 years, from 1969 through 1984 (DX 3, 22, Ex. 6).[5] For six months in 1984, claimant worked for employer as a mine security guard (DX 51 at 17). However, there is no indication that claimant's duties, which consisted of observing the mine property from a truck, qualified as coal mine employment (*see* DX 37 at 2 n.2; DX 51 at 17; *see also Falcon Coal Co. v. Clemons*, 873 F.2d 916, 922-23 (6th Cir. 1989)). Claimant's last and primary job as a coal miner was that of a shuttle car operator (DX 51 at 17). In this capacity, he hauled coal from the mine face and deposited it onto the feeder (DX 36 at 10). Clamant occasionally lifted bags of rock dust and loaded timbers, but otherwise, his job involved little manual labor (*id.* at 11, 13, 17). Claimant retired from U.S. Steel Mining in 1984, when employer shut down the mine at which he was working; he has not been employed in any capacity since that time (*id.* at 11, 13-14).

[4] Claimant's counsel offered six exhibits into the record on the claimant's behalf. However, Claimant's Exhibit 6 was already a part of the record as Director's Exhibit 65 (TR at 11-12).

[5] Claimant may actually have stopped working for U.S. Steel Mining on April 14, 1982. *See* DX 22, Ex. 10, 1. It is unclear whether he returned to work for the employer sometime after he filed his initial claim and then retired for good in 1984. No attempt will be made toresolve this uncertainty.

Claimant previously testified that as early as ten years prior to his retirement, he noticed "problems" with his breathing (*id.* at 12). He suffered shortness of breath upon exertion and had trouble climbing stairs (*id* at 12-13; DX 25 at 1). He had a cough that usually produced mucus and he was prescribed inhalers and cough syrup (DX 25 at 1, 36 at 12-13). Claimant "has a long history of hypertension, hypertensive cardiovascular disease, arteriosclerotic heart disease with past history of subendocardial infarction and congestive heart failure and supraventricular arrhythmia" (DX 38, *Admission History and Physical* at 1). He takes multiple medications for his breathing and heart problems (EX 2 at 1). At the hearing before Judge Holmes, claimant testified that his breathing problems had gotten worse since he testified before Judge Levin a little more than two years earlier (DX 51 at 18). Claimant stated that he was no longer able to work regularly in his garden or mow his lawn without stopping to rest (*id.* at 18-19). Finally, claimant has a lengthy smoking history. He began regularly smoking cigarettes in 1944 at the age of 17 (CX 1 at 2), smoking about ¾ of a pack per day until quitting around 1980 (DX 25 at 1; CX 1, at 2). Claimant has not smoked since then (DX 51 at 22).

Discussion

Since this is claimant's second request for modification of the denial of his duplicate claim for black lung benefits, §725.310 of the regulations is applicable.[6] In order to succeed on modification, claimant must establish either a change in conditions or a mistake in a determination of fact with respect to the previous denial of the claim as a prerequisite to having the denial of benefits reconsidered. *See* §725.310(a). Accordingly, I must determine whether the evidence filed since the previous denial of modification establishes that the claimant's condition has changed since Judge Levin denied the duplicate claim, or whether there has been a mistake in a determination of fact.

Change in Conditions

In *Kingery v. Hunt Branch Coal Co*., No. 92-1418 BLA (BRB Nov. 22, 1994), the BRB held that:

> in considering whether a claimant has established a change in conditions pursuant to 20 C.F.R. §725.310, an administrative law judge is obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

Id. at 1-11. Judge Levin found that claimant did not have pneumoconiosis and was not totally disabled (DX 37). Therefore, the evidence presented in connection with the instant request for

[6] The underlying duplicate claim was filed before January 19, 2001. Accordingly, some of the 2001 amendments to the regulations contained at 20 C.F.R. Parts 718 and 725, including those limiting the evidence that a party can submit, are not applicable in this case. §725.2(c)(2)(2001).

modification must establish that the claimant has pneumoconiosis or is totally disabled in order to establish a change in conditions with respect to the duplicate claim.

Under §718.202(a), pneumoconiosis can be established through x-ray, biopsy or autopsy evidence, the use of the presumptions at §§718.304-06, or well-reasoned medical opinions. Since the previous denial of modification, eight x-ray interpretations were admitted into evidence: Dr. Ahmed's positive reading of a January 8, 2003 x-ray (DX 65); Dr. Cardona's positive reading of a June 10, 2003 x-ray (CX 2 at 3, CX 4 at 8-9); positive readings of a March 17, 2004 x-ray by Drs. Patel, Alexander, Smith, and Gogineni (CX 1 at 28, 3; EX 3, 4); Dr. Baek's negative reading of the January 8, 2003 x-ray (EX 5); and Dr. Hippensteel's negative reading of a September 1, 2004 x-ray (EX 2 at 4). Two of the physicians interpreting x-rays on behalf of the employer (Drs. Smith and Gogineni) found x-ray evidence of pneumoconiosis. All of the interpreting physicians, except Dr. Cardona, are B-readers (government-certified experts in interpreting chest x-rays for pneumoconiosis) (CX 1 at 3, 3; EX 2-5; DX 65). Since a majority of the x-ray readings, including two by doctors interpreting x-rays for the employer, are positive, I find that the x-ray evidence submitted since the previous denial of modification is positive for pneumoconiosis.

The record is devoid of pathology evidence, and the presumptions at §§718.305 and 718.306 are not applicable. Finally, with respect to the physicians' opinions admitted since the previous denial of modification, only Drs. Hippensteel and Castle conclude that claimant does not have pneumoconiosis (EX 1-2). Dr. Hippensteel bases his conclusion on his negative reading of the claimant's chest x-ray (EX 2 at 2-3). Dr. Castle did not perform a chest x-ray in connection with his report, but bases his conclusion that claimant does not have pneumoconiosis on his previous negative chest x-ray interpretation and Dr. Hippensteel's 2004 x-ray reading (EX 2 at 3, 8). However, I have found that the x-ray evidence is positive for pneumoconiosis. Accordingly, the conclusions of Drs. Hippensteel and Castle on the issue of pneumoconiosis have no probative value. Since the other doctors whose recent opinions are in evidence all diagnose pneumoconiosis, the medical opinion evidence does not contradict the positive x-ray evidence.

Considering all of the foregoing, I find that claimant has established that he suffers from pneumoconiosis. Accordingly, claimant has established a change in conditions, and I will consider all of the evidence of record to determine whether he is entitled to benefits.

Total Disability

In order to receive benefits under the Act, claimant must not only prove the existence of pneumoconiosis, but that his pneumoconiosis arose out of his coal mine employment, that he is totally disabled from a respiratory or pulmonary standpoint, and that his disability is due to pneumoconiosis. §§718.203; 718.204. The regulations afford to a miner who worked 10 years or more in the coal mines and who is suffering from pneumoconiosis a rebuttable presumption that his pneumoconiosis arose out of such employment. §718.203(b). Given the parties' stipulation that claimant worked 29 years in the nation's coal mines (TR at 6), and the lack of evidence in the record to rebut the presumption, I find that claimant's pneumoconiosis arose out of his coal mine employment.

Next, claimant bears the burden of establishing that he has a totally disabling respiratory or pulmonary impairment. A miner is totally disabled if his pneumoconiosis prevents him:

> [f]rom performing his … usual coal mine work [ ] and [f]rom engaging in gainful employment in the immediate area of his … residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he … previously engaged with some regularity over a substantial period of time.

§718.204(b)(1)-(2). Claimant can establish total disability in several ways. Under §718.204(b), claimant will be considered totally disabled if the irrebuttable presumption at §718.304 applies. Further, claimant can establish that he has a totally disabling respiratory or pulmonary impairment through pulmonary function tests ("PFTs") and arterial blood gas tests, medical evidence showing that he suffers from cor pulmonale with right sided congestive heart failure, or reasoned medical opinions which conclude that he is totally disabled. §718.204(c)(1)-(4).

Under §718.304(a), claimant is entitled to an irrebuttable presumption of total disability due to pneumoconiosis if the chest x-ray evidence indicates complicated pneumoconiosis as evidenced by the presence of one or more large opacities (greater than 1 cm. in diameter) categorized as Category A, B, or C of the ILO-U/C Classification System. No x-ray evidence of complicated pneumoconiosis was presented in connection with the previous claim, the underlying duplicate claim, or the previous effort at modification. In this claim, only Dr. Alexander found evidence of an opacity classifiable as Category A on the March 17, 2004 chest x-ray (CX 3). However, in his narrative accompanying the x-ray interpretation, Dr. Alexander expresses doubt as to whether the opacity was in fact caused by pneumoconiosis (*id.*). He states that while the opacity was "consistent" with complicated pneumoconiosis, "[o]ther diseases might also [have] cause[d] this appearance," and he recommends further assessment with a chest CT scan (*id.*). Given Dr. Alexander's inconclusiveness with respect to the opacity and the fact that none of the other x-ray readings in the entire record indicate the presence of a large opacity, claimant has not established through x-ray evidence that the irrebuttable presumption of total disability under §718.304(a) is applicable. Further, there is no pathology or other evidence of complicated pneumoconiosis in the record.

Next, claimant can establish total disability through PFTs and arterial blood gas tests. §718.204(c)(1)-(2). Since the previous denial of modification, four PFTs were admitted into evidence: a January 8, 2003 PFT taken at Vansant Respiratory Care (DX 65); a PFT taken in connection with Dr. Cardona's examination (CX 5);[7] a March 17, 2004 PFT taken in connection with Dr. Rasmussen's examination (CX 1); and a September 1, 2004 PFT taken in connection with Dr. Hippensteel's examination (EX 2). Of these, three (DX 65; CX 5; EX 2) yielded values which meet the standards for presumptive total disability under Appendix B to Part 718 of the regulations. Only Dr. Rasmussen's PFT (CX 1 at 15) yielded values which do not meet the standards for presumptive total disability under the regulations.

[7] Although the report of the results of this PFT indicates that it was performed on June 9, 2003, Dr. Cardona testified at his deposition that it was performed on the day of his examination, which was June 10, 2003 (CX 4 at 8, 12-13).

A handwritten note accompanying the results of the January 8, 2003 PFT indicates that claimant was unable to perform the test because he became short of breath upon its commencement (DX 65). Accordingly, the results will not be considered. Similarly, with respect to Dr. Hippensteel's September 1, 2004 PFT, the docotor's notes accompanying the test results indicate that claimant "was unable to produce [a]cceptable and [r]eproducible [s]pirometry data" because he became dizzy and complained of being "weak and short of breath" (EX 2 at 7). Dr. Hippensteel remarks further that the spirometry and MVV data were invalid (*id*.).

With respect to the PFT conducted for Dr. Cardona, (CX 5), Dr. Cardona's comments in his report (CX 2 at 3), and his deposition testimony (CX 4 at 14), are shockingly confused (*see infra*). Yet there is no reason to assume that the test results themselves were reported inaccurately, and those results are very low (significantly less than half the predicted values), qualifying for presumptive total disability under Appendix B to Part 718 (*see* CX 5). However, there is no statement regarding the claimant's cooperation and comprehension. In light of the very low values produced, it raises the issue of whether this study is valid.

Finally, as was noted above, the March 17, 2004 PFT conducted by Dr. Rasmussen yielded non-qualifying values for presumptive total disability under the regulations (CX 1 at 15). In fact, the post-bronchodilator values are more than double those obtained for Dr. Cardona's examination, and are within the range of normal. Dr. Rasmussen stated that the PFT "revealed minimal, reversible obstructive ventilatory impairment." (*Id*. at 3).

Since the PFT is an effort-based test, it can produce results lower than a person is capable of achieving; but absent a mechanical malfunction, it cannot produce results higher than a person is capable of achieving. Further, Dr. Rasmussen's examination occurred after Dr. Cardona's, precluding any contention that the claimant's condition got worse subsequent to Dr.Rasmussen's PFT. Moreover, Dr. Rasmussen conducted his examination on behalf of the claimant. Accordingly, I find that Dr. Rasmussen's PFT is the most probative recent PFT, and not only does it fail to qualify for presumptive total disability, it is virtually normal.

The record also contains numerous PFTs conducted in connection with the previous proceedings in regard to the miner's claim for black lung benefits. *See* DX 6, 7; DX 22, Ex. 33 at 5; DX 25; DX 47, 52. These studies are predominantly non-qualifying for presumptive total disability. But they are of little import in light of the results produced in Dr. Rasmussen's test. Since the most recent probative PFT is non-qualifying, I find that claimant has not established total disability under 718.204(b)(2)(i).

Claimant may also establish total disability through arterial blood gas tests. Since the previous denial of modification, the reports of two arterial blood gas tests, conducted on March 17, 2004 and September 1, 2004, were admitted into evidence (CX 1 at 5; EX 2 at 15). The March 17, 2004 test conducted for Dr. Rasmussen's examination yielded at rest values (pCO_2 at 35 and pO_2 at 77) that were non-qualifying and peak exercise values (pCO_2 at 38 and pO_2 at 61) that were barely qualifying for presumptive total disability under Appendix C to Part 718 of the regulations (CX 1 at 5).[8] It should be noted, however, that Dr. Castle stated that a normal pO_2 value for a man the claimant's age at the elevation at which Dr. Rasmussen's test was taken

[8] With a PCO2 of 38, a PO2 of more than 62 would be non-qualifying.

would be 60.59 (EX 1 at 6). Claimant has not rebutted Dr. Castle's representation that the results obtained in Dr. Rasmussen's blood gas test are normal despite meeting the standard for presumptive total disability.[9] Accordingly, this arterial blood gas test does not establish that claimant is totally disabled even though it produced qualifying values for presumptive total disability under Appendix C. The September 1, 2004 test conducted for Dr. Hippensteel's examination, which was conducted at rest only, yielded non-qualifying values (pCO_2 at 36.7 and pO_2 at 75.0) (EX 2 at 15).

In regard to the arterial blood gas test evidence in the record from the earlier proceedings in this claim, the contemporaneous test before Judge Holmes was non-qualifying for presumptive total disability under the regulations (DX 38, 58), as were those before Judge Cox (DX 22, Ex. 33). Finally, three out of the four blood gas tests before Judge Levin yielded non-qualifying values, and the fourth was taken while the claimant was hospitalized with an acute illness (DX 9, 24-25, 37). In light of all the non-qualifying blood gas tests, as well as the representations by Dr. Castle that the March 17, 2004 exercise blood gas test was actually normal, I find that claimant has still not met his burden to establish total disability through arterial blood gas tests.

Next, claimant can establish total disability by establishing that he has pneumoconiosis and has been shown by the medical evidence to be suffering from cor pulmonale with right sided congestive heart failure. §718.204(c)(3). Judge Levin found that claimant suffered from right sided congestive heart failure but failed to establish the presence of cor pulmonale (DX 37). In this proceeding, claimant has established that he suffers from pneumoconiosis. However, the record contains no current medical evidence establishing the presence of cor pulmonale. Accordingly, claimant has not met his burden to establish total disability under §718.204(c)(3).

Finally, claimant can establish total disability through reasoned medical opinions. §718.204(c)(4). The opinions of four doctors were admitted into evidence since the previous denial of modification.

Dr. Cardona, who has been claimant's treating physician since at least December, 2001 (*see* CX 4 at 5), examined claimant at his request on June 9 or 10, 2003 (CX 2). Dr. Cardona took claimant's medical, work, and social histories, performed a physical examination, and had a chest x-ray, arterial blood gas test, and PFT performed (*id.*). Although the PFT (CX 5) yielded qualifying values for presumptive total disability under the regulations, it does not establish total disability for the reasons discussed above. Further, no pCO2 value was reported for the arterial blood gas test, so it cannot be determined whether this test qualifies for presumptive total disability under the regulations (CX 2 at 3).

In his narrative report, Dr. Cardona states that he is "qualified on the basis of [his] educational background and experience" to "unequivocally state" that claimant is "totally disabled due to his pulmonary status alone" and is "disabled permanently to perform any type of

[9] Dr. Cardona's muddled testimony regarding this issue (CX 4, at 14-16), even if probative, would tend to support Dr. Castle's opinion that normal blood gas test results are substantially lower in Southern West Virginia than at sea level.

physical duties comparable to his usual coal mining duties." (*id.*). But Dr. Cardona's expertise is questionable.

For one thing, Dr. Cardona misstates the results of the PFT conducted for his examination. Instead of stating that claimant's FEV_1 was 1.04 liters pre-bronchodilator and 1.18 liters post-bronchodilator (both of which were less than half of predicted), Dr. Cardona indicated that that these values were percentages of normal (CX 2 at 3; CX 4 at 14). Thus, he concluded that the results of the PFT were normal (CX 2 at 3; CX 4 at 14). Additionally, as noted, the PFT report is dated a day before Dr. Cardona states it was conducted. Since he insists the testing and his examination were conducted on the same day (CX 4, at 12-13), either he examined the claimant on June 9th or the tests were run on June 10th. Or he could be wrong and the examination was conducted a day after the testing. Although not in itself a major issue, it is indicative of the confusion and lack of precision surrounding Dr. Cardona's examination and report. Further, in discussing the results of the arterial blood gas test he had conducted, Dr. Cardona was at best confused regarding what the PO2 of 65.7 represented. He testified that it was a percentage of the oxygen inside the blood cells, and had to be reminded by employer's counsel that it was a measure of millimeters of mercury (CX 4, at 14-15). Finally, Dr. Cardona believes that *all* long-term miners have coal workers' pneumoconiosis (CX 4 at 18). All of these errors leave me with no confidence in his opinions or testing procedures.

Moreover, Dr. Cardona's conclusions are based on erroneous data. The narrative report indicates that claimant drastically underrepresented his smoking history, stating that he only smoked for 10 years (*id.* at 2). Second, Dr. Cardona demonstrated a substantial bias in favor of former coal miners. In his deposition, he indicates that he believes the medical standards for a claimant to be awarded benefits are much too stringent (*id.* at 17-20). Finally, his discussions of the results of the PFT and arterial blood gas tests (*id*. at 13-17, 20-22) border on the incoherent, and I have no confidence in his conclusions. Accordingly, I give no weight to Dr. Cardona's medical opinions in this case.

Dr. Rasmussen last examined the claimant on March 17, 2004. He took claimant's medical, occupational and social histories, and obtained a chest x-ray, PFT, an arterial blood gas test and electrocardiogram (CX 1). As discussed, the PFT yielded non-qualifying values for presumptive total disability under the regulations, and Dr. Rasmussen found only a "[m]inimal, reversible obstructive ventlatory impairment" (*id.* at 3, 16). Dr. Rasmussen concludes that claimant's resting arterial blood gases were normal, but his exercise blood gases showed a "moderate impairment in oxygen transfer" (*id.* at 3). The electrocardiogram revealed sinus bradycardia, but was "otherwise unremarkable" (*id.*). Claimant underwent an incremental treadmill exercise study, which yielded normal blood pressure and EKG responses, "moderate impairment" in oxygen transfer and minimal hypoxia (*id.*). Dr. Rasmussen concludes that the medical testing indicates a "moderate" loss of lung function that is evidenced by oxygen impairment during exercise (*id.*). Since this level of exercise "is far below that required" of claimant's previous coal mine employment, Dr. Rasmussen concludes that claimant does not retain the pulmonary capacity to perform his last coal mining job (*id.*).

However, Dr. Rasmussen's conclusion that claimant is totally disabled is based on the exercise blood gas test results, which Dr. Castle stated were normal for the elevation at which the test was conducted and for a male of claimant's age (EX 1 at 6). Second, even if he was correct that the claimant is totally disabled, he considers only claimant's coal mine employment and smoking as possible causes. Despite noting claimant's height (which he states is 67 inches) and weight (which he states is 223 pounds), Dr. Rasmussen never mentions that claimant is overweight and fails to consider whether claimant's obesity impacted his ability to transfer oxygen during exercise (*id.* at 2; *see also* DX 58 at 7; *cf*. EX 2, at 2). It should be pointed out that claimant weighed 30 pounds more as recently as June, 2003 (CX 4). More important, Dr. Rasmussen does not discuss whether the claimant's reduced blood gas test results may be due to claimant's heart disease, and the blood gas test is the only basis for Dr. Rasmussen's opinion that the miner is totally disabled. Accordingly, Dr. Rasmussen's opinion is seriously flawed.

Dr. Hippensteel, who is board-certified in pulmonary medicine (DX 22, Ex. 27), last examined the claimant on September 1, 2004 (EX 2). Dr. Hippensteel also took claimant's medical, occupational, and social histories, took a chest x-ray and obtained a PFT, an arterial blood gas test and an electrocardiogram (*id.*). The electrocardiogram was "abnormal . . . suggesting possible ventricular hypertrophy" (*id.* at 2). Further, as discussed above, the spirometry was invalid on account of claimant's inability to complete the PFT (*id.* at 7). Additionally, Dr. Hippensteel was only able to obtain arterial blood gases taken at rest (*id.* at 15). Dr. Hippensteel concludes that the claimant does not have pneumoconiosis. He adds that claimant "appears unable as a whole man" to go back to his job in the mines, but attributes claimant's disability to his age and non-pulmonary problems (*id.*). Dr. Hippensteel also concludes that the "effort independent" tests do not show pulmonary impairment that would keep claimant from returning to his job in the mines (*id.*). However, given that both of Dr. Hippensteel's conclusions are based on incomplete objective data, and he believes the claimant does not have pneumoconiosis, his opinion is entitled to limited weight.

By letter dated July 18, 2006, Dr. Castle wrote a consultative report based on his review of his own previous medical reports concerning the claimant, medical reports from Drs. Cardona, Hippensteel and Rasmussen, chest x-ray interpretations by Drs. Ahmed, Alexander, Baek, Gogineni, and Smith, Dr. Cardona's deposition transcript, and the previous decisions rendered in this case (EX 1). On the basis of his review of all of this evidence, Dr. Castle concluded that claimant does not have pneumoconiosis and is not permanently and totally disabled (*id*. at 8). He states that the "valid physiologic studies" showed evidence of "mild, significantly reversible airway obstruction without restriction or diffusion abnormality," but the claimant does not demonstrate a "disabling abnormality of ventilatory function from any cause" (*id.*). Dr. Castle finds further that claimant's airway obstruction is "consistent" with bronchial asthma or asthmatic bronchitis" and that it is "entirely possible" that claimant's disability results from his "age, cardiac disease, obesity, and bronchial asthma" (*id.*).

Dr. Castle's opinion as expressed on July 18, 2006 is the best reasoned in the record regarding claimant's current condition. It also is based on the most medical evidence. The only catch is that he does not believe the claimant has pneumoconiosis. But regardless of whether the claimant has pneumoconiosis, Dr. Castle finds no disabling respiratory or pulmonary

impairment, and this conclusion is very well explained and consistent with the evidence in the record.

The record from the miner's earlier claims contains reports from Drs. Castle (April 10, 1997 – DX 25; March 5, 2001 – DX 52), Hippensteel (August 5, 1983 - DX 22, Ex. 27), Krishnan (November 25, 1995, December 5, 1995 – DX 24; May 20-21, 1998 – DX 38), Salmassi (May 21, 1998 - DX 38), Najjar, claimant's treating cardiologist (DX 49 – August 21, 1998), Rasmussen (August 8, 1983 – DX 22, Ex. 16), and Vasudevan (January 5, 1996 (DX 8). In both of his earlier reports, Dr. Castle found that the claimant did not have pneumoconiosis and had a reversible airway obstruction which was not totally disabling. Similarly, in 1983, Dr. Hippensteel concluded that the claimant did not have pneumoconiosis and had minimal pulmonary disfunction. Dr. Krishnan's 1998 reports relate to a hospitalization from May 20-21, 1998 resulting from an automobile accident, and another hospitalization from November 25-December 5, 1995 due to abdominal and lower back pain and urinary difficulties. The most important thing about these reports is that they document a significant history of heart disease. They also note a history of chronic obstructive pulmonary disease with pneumoconiosis. However, Dr. Krishnan does not address whether the claimant's lung disease is totally disabling. Dr. Salmassi also treated the claimant during his 1998 hospitalization and does not discuss whether claimant has a totally disabling respiratory or pulmonary impairment.

That leaves the reports of Drs. Najjar, Rasmussen and Vasudevan. Dr. Vasudevan performed the Department's pulmonary evaluation on the claimant in 1996. He concluded that claimant suffered from "moderate restrictive lung function," yet wrote "none" in the sections of the report form relating to cardiopulmonary diagnoses and impairment (DX 6-8). Dr. Vasudevan offers no explanation for this inconsistency, and his opinion is not entitled to any weight. In any event, he does not conclude that the claimant has a totally disabling respiratory or pulmonary impairment. Dr. Najjar, a board-certified cardiologist (DX 49), wrote a short letter to claimant's lay representative at that time in regard to the claimant's 1995 hospitalization. He appears to have been one of the doctors treating the claimant during that hospitalization. In this letter, Dr. Najjar states that the claimant was hospitalized for heart failure and paroxysmal atrial fibrillation. He goes on to state that it was "obvious" these conditions resulted, in whole or in part, from claimant's coal workers' pneumoconiosis. He also states that claimant has "moderately severe chronic obstructive lung disease" and that his right-sided heart failure is due to pneumoconiosis. But he does not diagnose cor pulmonale, and never directly opines that the claimant is totally disabled (DX 33). Regardless, Dr. Najjar provides absolutely no support for his diagnoses or conclusions. Finally, Dr. Rasmussen conducted the Department's black lung examination in 1983. At that time, he diagnosed coal workers' pneumoconiosis. He also stated that the claimant's ventilatory studies were normal, his ventilatory response to exercise was normal, and his gas exchange was only minimally impaired during exercise. From these studies, Dr. Rasmussen concluded that claimant had "minimal but significant impairment", which is oxymoronic, and stated that he is "incapable of performing heavy or manual labor. Dr. Rasmussen's opinion as expressed in 1983 was inconsistent with the results of his examination and poorly explained. It is entitled to little weight.

Based on all of this evidence, I find that the claimant has failed to prove that he has a totally disabling respiratory or pulmonary impairment. Regardless of the weight to be given to

the recent reports of Drs. Castle and Hippensteel, the recent opinions of Drs. Cardona and Rasmussen do not provide substantial evidence that the miner has a totally disabling respiratory or pulmonary impairment, regardless of the cause. Nor does the evidence in the record from the period before the 2003 claim was filed support a finding that the miner has a totally disabling respiratory or pulmonary impairment. Since the claimant has the burden of proof, *see Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), his failure to affirmatively prove that he has a totally disabling respiratory or pulmonary impairment dooms his claim regardless of the contrary evidence in the record.

Considering the newly submitted medical opinion evidence, which I find is negative for total disability, in conjunction with the previous medical opinion evidence of record, I find that claimant has still not met his burden to establish that he is totally disabled from a respiratory or pulmonary standpoint through the medial opinions. *See* §718.204(c)(4). Accordingly, although his condition has changed and he now has pneumoconiosis, he has not established his entitlement to benefits.

Mistake of Fact

Modification can also obtained through a showing that the previous decision denying benefits was based on a material mistake in a determination of fact. Claimant has not pointed to any material mistakes of fact with respect to the previous denials of this claim. Further, I have reviewed the record independently. Although Judge Holmes incorrectly concluded that one pre-bronchodilator PFT value was non-qualifying for total disability, this evidence is insufficient to establish that claimant is totally disabled from a pulmonary or respiratory standpoint. I find no other mistakes and conclude that the evidence of record fails to establish that the claimant has a totally disabling respiratory or pulmonary impairment.

Since the evidence fails to show that there was a material mistake in a determination of fact, or that claimant, despite the change in conditions, has developed a totally disabling respiratory or pulmonary impairment, benefits must again be denied.

ORDER

IT IS ORDERED that the second proceeding for modification of the denial of the duplicate claim of C.F. is **DENIED**.

A

JEFFREY TURECK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. §725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision